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ABSTRACT

Empirical evidence suggests that client gender, client sexual orientation, counselor gender, and counselor sexual orientation are factors that influence counselors' attitudes and treatment practices with lesbian, gay, and bisexual (LGB) clients. However, it is unclear how these factors may interact to affect attitudes and treatment practices. Moreover, no recent studies have examined attitudes and treatment practices among licensed psychologists, who may engage in both clinical and training responsibilities (thereby affecting both clients and trainees). This study compared licensed psychologists' attitudes and clinical evaluations for clients of differing sexual orientations. After reading a vignette describing a lesbian female, gay male, bisexual female, bisexual male, heterosexual female, or heterosexual male client, 303 licensed psychologists completed a Semantic Differential, a Self-Attribution Scale, the Global Assessment of Functioning, a Treatment Process and Outcomes Expectations Questionnaire, and a demographic questionnaire. Results indicated that female participants held more positive attitudes and expected greater improvement in clients' problems than did male participants. A significant interaction effect was found for client sexual orientation and participant gender. Results of content analyses supplemented quantitative findings suggested that participants did not consider sexual orientation to be an appealing issue. (Contains 58 references.) (GCP)

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Psychologists' Attitudes and Clinical Evaluations for LGB Clients

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Abstract

Empirical evidence suggests that client gender, client sexual orientation, counselor gender, and counselor sexual orientation are factors that influence counselors' attitudes and treatment practices with lesbian, gay, and bisexual (LGB) clients. However, it is unclear how these factors may interact to affect attitudes and treatment practices. Little is known about attitudes and treatment practices with bisexual clients in particular. Moreover, no recent studies have examined attitudes and treatment practices among licensed psychologists, who may engage in both clinical and training responsibilities (thereby affecting both clients and trainees). This study compared licensed psychologists' attitudes and clinical evaluations for clients of differing sexual orientations. After reading a vignette describing a lesbian female, gay male, bisexual female, bisexual male, heterosexual female, or heterosexual male client, 303 licensed psychologists (159 women and 144 men) who were members of the American Psychological Association completed a Semantic Differential, a Self-Attribution Scale, the Global Assessment of Functioning, a Treatment Process and Outcomes Expectations Questionnaire, and a demographic questionnaire. The study utilized a 2 (participant gender) x 2 (client gender) x 3 (client sexual orientation) between subjects design, with participant sexual orientation as a covariate. MANCOVA results indicated that female participants held more positive attitudes and expected greater improvement in clients' problems than did male participants. A significant interaction effect was found for client sexual orientation and participant gender. Results of content analyses supplemented quantitative findings and suggested that participants did not consider sexual orientation to be an appealing issue.

Psychologists' Attitudes and Clinical Evaluations for LGB Clients

Research suggests that many lesbian, gay, and bisexual (LGB) individuals seek counseling services (e.g., Bieschke, McClanahan, Tozer, Grzegorek, & Park, 2000; Liddle, 1997) and at higher rates than among heterosexual people (e.g., Bieschke et al., 2000). Although many LGB individuals seek treatment, they constitute a largely "hidden minority" (Fassinger, 1991, p. 157) whose therapeutic needs may not be met effectively. Although homosexuality was declassified as a mental illness by both the psychological and psychiatric professions by the mid-1970's, many scholars have asserted that the mental health field continues to be plagued by number of professionals whose therapeutic and/or training interventions are negatively influenced by their homophobic, biphobic, and heterosexist beliefs (e.g., Eliason, 1997; Rust, 1996).

Indeed, findings of an emerging body of empirical literature suggest that many counselors' attitudes and reactions are apt to be influenced by negative biases, compounded by a lack of adequate training (e.g., Gelso, Fassinger, Gomez, & Latts, 1995; Phillips & Fischer, 1998). Notably, of these studies only one (Phillips & Fischer, 1998) included bisexuality within its scope. All other studies examined counselors' attitudes and reactions solely toward lesbian and/or gay individuals. As a result, there is no clear indication from this body of literature about counselors' attitudes and reactions toward bisexual clients. With respect to lesbian and gay clients, however, results from these studies suggest that counselors' attitudes and reactions are generally negative or mixed at best.

Empirical evidence also suggests that client gender, client sexual orientation, counselor gender, and counselor sexual orientation are factors that influence counselors' attitudes and treatment practices with LGB clients (e.g., Bieschke & Matthews, 1996; Gelso et al., 1995).

Findings from two studies indicated that female counselors held more positive attitudes than did male counselors (Garfinkle & Morin, 1978; Thompson & Fishburn, 1977). Another more recent study, which examined counselors' countertransference reactions to lesbian clients (Gelso et al., 1995), documented an interaction effect between counselor gender and client sexual orientation – that with lesbian clients, female counselors made significantly more errors in cognitive recall than did male counselors. Of the four studies that have investigated treatment practices with LGB clients (Bieschke & Matthews, 1996; Garnets, Hancock, Cochran, Goodchilds, & Peplau, 1991; Liddle, 1996, in press), two have found counselor gender and sexual orientation to be salient factors influencing appropriate and inappropriate counseling practices with this population (Bieschke & Matthews, 1996; Liddle, 1996). Given the state of this nascent body of research, however, it is unclear how client gender, client sexual orientation, counselor gender, and counselor sexual orientation may interact to affect attitudes and treatment practices.

A striking feature of the body of literature on counselor attitudes, reactions, and treatment practices is the nearly complete absence of studies addressing bisexuality and bisexual clients. In this research domain, only two studies (Bieschke & Matthews, 1996; Phillips & Fischer, 1998) have addressed bisexuality. As a result, very little is known about counselors' attitudes and reactions toward bisexual clients or about appropriate and inappropriate counseling practices with bisexual clients. The existing literature on bisexuality focuses on general attitudes toward bisexual individuals and suggested treatment practices and is primarily theoretical or autobiographical in nature. However, findings from one empirical study on general attitudes toward bisexuality suggest that attitudes are influenced by beliefs about a) moral tolerance for same sex attraction and b) stability of bisexuality – namely, the legitimacy of bisexuality as a valid sexual orientation and reliability in maintaining relationships (Mohr & Rochlen, 1999).

Given the limited empirical research in this area, it is imperative that future research examine counselors' attitudes and reactions to bisexual clients and counseling practices with this population.

The purpose of this study was to compare licensed psychologists' attitudes and clinical evaluations according to differences in client sexual orientation, client gender, and participant gender. The study used a 2 (participant gender) x 2 (client gender) x 3 (client sexual orientation) between subjects design, with participant sexual orientation as a covariate.

Method

Participants

Participants were members of the American Psychological Association and were contacted by purchasing a mailing list from this organization. A total of 600 potential participants (300 men and 300 women), who were licensed and who provided more than three hours of mental health services per week, were randomly selected to participate in this study.

Of the 600 APA members who were mailed surveys, 5 were excluded because they did not meet criteria for the study (e.g., were not licensed; were not in clinical practice), 2 were excluded because survey packets were undeliverable, and 1 person was deceased. Of the remaining 592 potential participants, 319 returned surveys (53.9% response rate). However, 11 of these surveys were unusable (e.g., returned after analyses were completed; participant's assigned condition was unidentifiable), and 5 cases were later deleted due to missing data. The final number of usable responses was 303 from the original sample of 592 (51.2% response rate).

Of the 303 individuals who returned usable surveys, 159 were female and 144 were male. Respondents ranged in age from 30 to 91 (M = 52.6). Two hundred ninety-two participants identified as White, non Latino/a (96.4%), four as Hispanic or Latino/a (1.3%), three as African-

American or Black (1%), and two as Asian American (.7%). One respondent identified as "other" but did not specify a racial/ethnic identity. One respondent declined to identify a particular race/ethnicity. In terms of sexual orientation, 150 respondents identified as primarily heterosexual women (49.5%), 136 as primarily heterosexual men (44.9%), 8 as primarily lesbian women (2.6%), 6 as primarily gay men (2%), 2 as primarily bisexual men (.6%), and 1 as a primarily bisexual woman (.3%). With respect to educational degree, 248 respondents had earned a Ph.D. (81.8%), 28 had earned a Psy.D. (9.2%), 19 had earned an Ed.D. (6.3%), 6 had earned a M.A. (2%), and 2 had earned a M.S. (.7%). The majority of respondents (72.9%) reported that they had provided some type of training within the past year.

Procedures

Participants were mailed a packet that included a cover letter describing the study, the study materials, a stamped addressed envelope to return completed forms, and a stamped addressed postcard. The cover letter insured the anonymity of participants' responses and explained that participants should return the enclosed postcard separately from the survey materials to indicate anonymously that they had completed the questionnaire. As an incentive for participation, the letter stated that the principal investigator would donate $.50 to the American Diabetes Association for every completed and returned survey. There were two follow-up mailings to nonrespondents.

After reading a clinical vignette, participants completed five measures: a Semantic Differential, the Self-Attribution Scale, the Global Assessment of Functioning, a Treatment Process and Outcomes Expectations Questionnaire, and a demographic questionnaire. The presentation of the measures was counterbalanced to minimize any ordering effects on

participant responses. The demographic questionnaire was presented as the last measure for participants to complete.

Measures

Vignette. Participants were presented with a vignette, developed for this study, as the primary stimulus. Two of the independent variables (client gender and client sexual orientation) were manipulated, while all other details were identical across each of the six conditions. The client was portrayed as one of the following: a lesbian woman, a gay man, a bisexual woman, a bisexual man, a heterosexual woman, or a heterosexual man. The vignette described a client experiencing moderate depressive symptoms related to difficulties managing a chronic illness and feeling isolated and misunderstood in relationships.

Semantic Differential. An 18-item Semantic Differential (SD; Osgood, Suci, & Tannenbaum, 1957) assessed attitudes toward the client described in the vignette. The SD has been used in psychological research to assess attitudes in various contexts (e.g., Biro, 1995), including previous studies examining sexual orientation issues (e.g., Glenn & Russell, 1986). The scale consists of bipolar adjective pairs, each rated on a seven-point Likert scale. Of the 18 items, seven adjective pairs comprised an evaluative factor; six represented a potency factor; and five reflected an activity factor. Various studies have found a consistent factor structure and adequate factor loadings for the 18 adjective pairs ranging from .43 to .88 (e.g., Oyama, Yamada, & Iwasawa, 1998; Skrandies, 1998).

Self-Attribution Scale. Attributions of responsibility for problem cause and solution were measured using the Self-Attribution Scale (SAS; Karuza, Zevon, Gleason, Karuza, & Nash, 1990), a six-item instrument comprised of three items for attribution of problem cause and three items for attribution of problem solution. Each item utilizes a seven-point Likert scale ranging

from (1) not at all to (7) very much. The SAS has been shown to have adequate psychometric properties in several studies. Internal consistency has been found to range from .76 to .86 for the Cause items and from .58 to .79 for the Solution items (Hayes & Wall, 1998; Karuza et al., 1990; McCracken, Hayes, & Dell, 1997). Two-week test-retest reliability has be shown to be .86 for the Cause items and .70 for the solution items (Bailey & Hayes, 1996). Several studies have provided evidence of concurrent validity and construct validity for the Cause and Solution items (Hayes & Wall, 1998; Karuza et al., 1990; McCracken et al., 1997).

Global Assessment of Functioning. The Global Assessment of Functioning (GAF) is a single-item scale listed in the DSM-IV as an Axis V diagnostic criterion test. The purpose of the GAF is for the clinician to assess "the individual's overall level of functioning" (American Psychiatric Association, 1994, p. 30) for such purposes as planning treatment. Existing psychometric data indicates that the GAF has adequate reliability and validity. Reliability estimates have been found to range from .53 to .76 (Jones, Thornicroft, Coffey, & Dunn, 1995; Rey, Starling, Wever, Dossetor, & Plapp, 1995) for clinical populations. A few studies have examined the validity of the GAF. The GAF has been shown to be well-correlated (-0.73) with the Zung Depression scores (the negative correlation occurring because a higher number represents more severe mental illness on the Zung scores) (Hall, 1995). In a field trial in which social, occupational, and clinical data were examined for patients receiving outpatient mental health services, Patterson and Lee (1995) found adequate convergent and discriminant validity for the GAF. Finally, Robert, Aubin, Dumarcet, Braccini, and Souetre Darcourt (1991) reported that approximately 64% of variation in GAF ratings were accounted for by Axis I diagnoses. Regarding its use in psychological research, the GAF has been used in many studies (e.g., Kennedy, Madra, & Reddon, 1999; Manassis & Hood, 1998; Svanborg, Gustavsson, & Weinryb,

1999) – mostly in conjunction with other measures of symptomatology to assess various clinical and treatment issues (Piersma & Boes, 1997).

Treatment Process and Outcomes Expectations Questionnaire. A ten-item Treatment Process and Outcomes Expectations Questionnaire (TPOEQ), developed by the authors, assessed expectations of treatment process and outcome. Psychometric data for this experimental measure has not been established.

Quantitative items. The first six questions assess expectations of the course and outcome of treatment with the client in the vignette. The initial question is open-ended: "How many sessions would you expect to work with this client in individual therapy?" The other five items utilize a seven-point Likert scale ranging from (1) not at all likely to (7) very likely: (a) "How likely is it that Chris' depressive symptoms will improve with individual therapy?"; (b) "How likely is it that Chris' relationship problems will improve with individual therapy?"; (c) "How likely is it that Chris will require hospitalization during the course of individual therapy?"; (d) "How likely is it that Chris will become actively suicidal during the course of individual therapy?"; and (e) "How likely is it that Chris will threaten to physically harm another person during the course of individual therapy?" Next, two items ask about levels of comfort and interest, respectively, in working with the client. These items utilize a seven-point Likert scale ranging from (1) not at all to (7) very much so: (a) "How comfortable would you be if you were working with Chris in individual therapy?"; and (b) "How interested would you be to work with Chris in individual therapy?"

Content analysis items. The TPOEQ includes two open-ended questions: (a) "What do you find most appealing about this client?"; and (b) "What do you find least appealing about this client?"

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Demographic Questionnaire. A demographic questionnaire prepared by the authors assessed several personal and professional variables: sex, sexual orientation, age, ethnicity/race, training background, and current training responsibilities.

Results

Pre-Analysis Procedures

Prior to conducting analyses, data were checked for missing values. Five cases were deleted because of missing data. Data were also examined to determine that they fulfilled the assumptions necessary for multivariate analysis: normality of distribution, univariate and multivariate homogeneity of variance, non-existence of multicollinearity, and non-existence of outliers.

To verify that the SD and the SAS demonstrated acceptable internal consistency and reliability for the data in this particular study, coefficient alpha estimates of internal reliability were computed for the three SD factors as described by Osgood et al. (1957) and for the two SAS factors as proposed by Karuza et al. (1990). Coefficient alpha estimates and subsequent principal components analyses are presented separately for the SD and the SAS, respectively.

SD. Coefficient alpha values were calculated for the three factors of the SD, described by Osgood et al. (1957): evaluative, potency, and activity. For the evaluative factor, the coefficient alpha value was .74, which is considered acceptable (George & Mallery, 2000). The coefficient alpha value for the potency factor was .48, which is considered unacceptable (George & Mallery, 2000). The coefficient alpha value for the activity factor was .52, which is considered poor (George & Mallery, 2000). Because of the low internal reliability and consistency values for the potency and activity factors, a principal components analysis was conducted to test how well the data fit the three factors developed by Osgood et al. (1957).

Moreover, this analysis was conducted in order to produce different factors with more acceptable coefficient alpha values if the data did not fit the Osgood et al. (1957) three-factor model.

A Varimax principal components analysis was conducted on the 18 SD items. Three criteria were used to determine the number of factors: eigenvalues greater than 1, the scree test, and rotated factor loading values greater than or equal to .45 (Tabachnick & Fidell, 1996).

The initial rotated solution produced five factors with eigenvalues greater than 1. Based on the scree plot criteria, these five factors were reducible to either two or three factors. To determine whether to use two or three factors, a second Varimax principal components analysis was conducted to extract three components. Because only one item loaded highly on the third factor, the two-factor model provided a more suitable fit for the data (Tabachnick & Fidell, 1996). Next, a third Varimax principal components analysis was conducted to produce two components. The rotated solution yielded two factors: eight items on an evaluative factor and six items on a dynamism factor. The two SD factors were significantly correlated ($r = 0.438$, $p < .001$).

This resulting two-factor model is consistent with the findings of Osgood et al. (1957), who reported that the three original SD factors (evaluative, potency, and activity) may collapse into two factors when the SD is used to assess attitudes toward "sociopolitical concepts (people and policies)" (p. 74). The authors denoted these two factors as an evaluative factor and a "coalescence of the [potency and activity] factors into what might be called a 'dynamism factor'" (p. 74). The evaluative factor refers to judgments about worth or value (e.g., good/bad; valuable/worthless). The dynamism factor reflects judgments about power and strength (e.g., strong/weak; active/passive).

Finally, a reliability analysis was conducted on the two SD factors. For the evaluative factor, the coefficient alpha was .80, which is considered good (George & Mallery, 2000). The coefficient alpha for the dynamism factor was .72, which is considered acceptable (George & Mallery, 2000). These two factors of the 14-item SD were used for subsequent analyses.

SAS. For the attribution of responsibility for problem cause factor, the coefficient alpha was .79, which is considered acceptable (George & Mallery, 2000). For the attribution of responsibility for problem solution factor, the coefficient alpha was .50, which is considered poor (George & Mallery, 2000). Because of the poor internal reliability and consistency value for the problem solution factor, a principal components analysis was conducted to test how well the data fit the two-factor model originally devised by Karuza et al. (1990) or, alternately, to generate different factors with more acceptable coefficient alpha values if the data did not fit the Karuza et al. (1990) model.

A Varimax principal components analysis was conducted on the six SAS items. The same criteria as described above were utilized to determine the number of factors for the SAS: eigenvalues greater than 1, the scree test, and rotated factor loading values greater than or equal to .45 (Tabachnick & Fidell, 1996). The rotated solution yielded two interpretable factors, consistent with the Karuza et al. (1990) model: attribution of responsibility for problem cause and attribution of responsibility for problem solution. The two SAS factors were not significantly correlated ($r = -0.012$, $p = .84$).

Analyses

Quantitative analyses. The first research question addressed differences between groups on factor scores of the SD. It was hypothesized that there would be significant differences in the two SD factors (evaluative and dynamism) for the lesbian female, gay male, bisexual female,

bisexual male, heterosexual female, and heterosexual male client conditions. Moreover, it was expected that bisexual male clients would be rated most negatively on the two SD factors, followed bisexual female clients, gay male clients, lesbian female clients, heterosexual female clients, and then heterosexual male clients. Contrary to this expectation, MANCOVA results showed no significant interaction effects among groups on the evaluative and dynamism factors (Wilks' lambda = .99, F (2, 290) = .88, p = .478). Also, participant sexual orientation was not found to have a significant effect as a covariate (Wilks' lambda = .99, F (1, 290) = 1.91, p = .151).

However, participant gender (Wilks' lambda = .98, F (2, 290) = 3.18, $p < .05$; eta squared = .02) and client gender (Wilks' lambda = .96, F (2, 290) = 6.66, $p < .05$; eta squared = .04) were each found to have significant main effects. For participant gender, follow-up univariate ANCOVAs showed a significant effect for the dynamism factor (F (1, 290) = 5.77, $p < .05$; eta squared = .02). This result indicated that female participants rated clients higher (more positively) on the dynamism factor than did male participants. For client gender, follow-up univariate ANCOVAs showed a significant effect for the dynamism factor (F (1, 290) = 10.72, $p < .01$; eta squared = .04). This result showed that female clients were rated higher (more positively) on the dynamism factor than were male clients.

The second research question examined differences between groups on factor scores of the SAS. It was hypothesized that there would be significant differences in the two SAS factors (attribution of responsibility for problem cause and attribution of responsibility for problem solution) for the lesbian female, gay male, bisexual female, bisexual male, heterosexual female, and heterosexual male client conditions. It was expected that bisexual male clients would be rated as most responsible for problem cause and solution, followed bisexual female clients, gay

male clients, lesbian female clients, heterosexual female clients, and heterosexual male clients, respectively. In contrast to this expectation, however, MANCOVA results showed no significant interaction effects among groups on either of the two SAS factors (Wilks' lambda = .97, F (2, 290) = 2.22, p = .066). Moreover, participant sexual orientation was not found to have a significant effect as a covariate (Wilks' lambda = .99, F (1, 290) = 1.06, p = .349).

However, participant gender was found to have a significant main effect (Wilks' lambda = .92, F (1, 290) = 11.85, p < .001; eta squared = .08). For participant gender, univariate follow-up ANCOVAs indicated a significant effect for the attribution of responsibility for problem cause factor (F (1, 290) = 20.34, p < .001; eta squared = .07). This result indicated that male participants rated clients higher (more responsible for problem cause) than did female participants.

Research question 3 addressed differences between groups on GAF scores. It was expected that bisexual male clients would be rated lowest, followed by bisexual female clients, lesbian female clients, gay male clients, heterosexual female clients, and heterosexual male clients, respectively. Contrary to this expectation, the ANCOVA showed no significant effects (F (2, 290) = .27, p = .767). Also, participant sexual orientation was not found to have a significant effect as a covariate (F (1, 290) = .57, p = .453).

Research question 4 examined differences between groups for TPOEQ ratings. It was hypothesized that participants would rate bisexual male clients as having longer treatment needs and more difficulties during treatment, followed by bisexual female clients, gay male clients, lesbian female clients, heterosexual female clients, and heterosexual male clients, respectively. It was also expected that comfort and interest ratings would be lowest for heterosexual male participants regarding bisexual male clients and gay male clients, respectively. In contrast to

these expectations, MANCOVA results showed no significant three-way interaction effects among groups on treatment expectations ratings (Wilks' lambda = .93, F (2, 290) = 1.40, p = .134). Participant sexual orientation was not found to have a significant effect as a covariate (Wilks' lambda = .98, F (1, 290) = .82, p = .585).

However, a significant two-way interaction was found between client sexual orientation and participant gender (Wilks' lambda = .89, F (2, 290) = 2.08, $p < .01$; eta squared = .06). Follow-up univariate ANCOVAs for the client sexual orientation and participant gender interaction showed a significant effect for items #2 (F (2, 290) = 3.30, $p < .05$; eta squared = .02) and #6 (F (2, 290) = 3.58, $p < .05$; eta squared = .02) on the TPOEQ. ANOVAs were conducted as post hoc tests for items #2 and #6, and graphs depicting these interaction effects are presented in Figures 1 and 2, respectively.

For item #2, results of the Bonferroni method indicated a significant difference between ratings of heterosexual clients and bisexual clients (F (2, 290) = 3.25, $p < .05$; eta squared = .02). Also, there was a significant difference in ratings by female participants and male participants (F (1, 290) = 15.35, $p < .001$; eta squared = .05). These results indicated that female participants rated bisexual clients significantly higher (more likely to improve) than heterosexual clients; male participants' ratings did not differ significantly across the lesbian or gay, bisexual, or heterosexual client conditions.

For item #6, results of the Bonferroni method showed a significant difference between ratings of lesbian, gay, and bisexual clients and ratings of heterosexual clients (F (2, 290) = 4.12, $p < .05$; eta squared = .03). There was also a significant difference in ratings by female participants and male participants (F (1, 290) = 9.47, $p < .01$; eta squared = .03). These results indicated that male participants rated lesbian, gay, and bisexual clients significantly higher (more

likely to harm another person) than heterosexual clients; female participants' ratings did not differ significantly across the lesbian or gay, bisexual, or heterosexual client conditions.

Also, participant gender was found to have a significant main effect (Wilks' lambda = .89, $F(1, 290) = 4.16$, $p < .001$; eta squared = .11). Main effects were not reported for those items that had a significant interaction effect (#2 and #6) because it is generally not meaningful to interpret main effects in the presence of an interaction (Pedhazur & Schmelkin, 1991; L. M. Jome, personal communication, July 25, 2000). Therefore, main effects were interpreted for items that did not have a significant interaction effect. Follow-up univariate ANCOVAs for the participant gender main effect indicated significant main effects for items #3 ($F(1, 290) = 10.30$, $p < .01$; eta squared = .03), #4 ($F(1, 290) = 8.28$, $p < .01$; eta squared = .03), #5 ($F(1, 290) = 13.15$, $p < .001$; eta squared = .04), #7 ($F(1, 290) = 5.16$, $p < .05$; eta squared =.02), and #8 ($F(1, 290) = 6.59$, $p < .05$; eta squared = .02) on the TPOEQ. These results showed that female participants rated clients significantly higher on item #3 (more likely to improve relationship problems with individual therapy) than did male participants. In contrast, male participants rated clients significantly higher on items #4 (likelihood of psychiatric hospitalization during individual therapy) and #5 (likelihood of becoming actively suicidal during treatment) than did female participants. Finally, male participants reported feeling more comfortable to work with the client (item #7) than female participants did, whereas female participants reported greater interest in working with the client (item #8) than did male participants.

Content analyses. The authors conducted content analyses on participants' responses to two open-ended questions on the TPOEQ: what they considered the most appealing and least appealing aspects of the client. Categories of responses were generated through a process of informally "eyeballing" participants' statements. It should be noted that although the content

analyses produced numerous categories for each of the two questions, only particular findings that are most relevant to this study are presented. Namely, participants' responses in categories related to sexual orientation or relationship issues, for instance, are stressed. Statements associated with other issues (such as adoption concerns or depressive symptoms, for example) are deemphasized in the discussion of results. Therefore, results from the content analyses should be considered as an informative supplement to quantitative data but should not be overemphasized.

In terms of what participants reported as most appealing, sexual orientation was not clearly identified as an appealing issue to address in therapy. Only a small number of respondents mentioned sexual orientation as an appealing aspect of lesbian clients' and gay clients' issues. Not one participant reported sexual orientation as an appealing issue about bisexual female clients or bisexual male clients. Of the limited number of responses addressing the client's sexual orientation, there were some apparent differences in the legitimacy of sexual orientation issues between gay and lesbian clients and bisexual clients. Namely, participants in the lesbian and gay client conditions more frequently mentioned issues related to sexual orientation as most appealing than did participants in the bisexual male and female client conditions.

Participants reported sexual orientation-related issues as the least appealing aspect of the client more often than they mentioned sexual orientation-related issues as the most appealing aspect of the client. Several participants specifically identified sexual orientation as the least appealing aspect of the client. The majority of the participants who identified sexual orientation as least appealing were in the bisexual male and female client conditions. Participants tended to describe bisexual clients as confused, impulsive, and having potentially longstanding identity

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issues. In contrast, participants framed their reactions to lesbian and gay clients as discomfort with or disapproval of lesbian or gay lifestyles or identities. Finally, several participants expressed concern about their own countertransference reactions and lack of training related to medical issues, yet only one respondent indicated a similar concern about countertransference and lack of training regarding sexual orientation issues.

Lastly, there were differences in responses according to participant gender. Female participants more frequently reported relationship issues and sexual orientation issues as appealing than did male participants. However, male participants identified identity concerns and the client's experience of feeling different from others and as appealing issues relatively more frequently than female participants did.

Discussion

This study's most consistent finding is that participant gender accounted for significant differences in reported attitudes and clinical evaluations of clients as assessed by several dependent measures. Results indicated that female participants generally held more positive attitudes toward all clients than male participants did. Female participants considered clients to be stronger and more active than did male participants. Female participants also rated clients as less responsible for the cause of their problems than did male participants. In terms of clinical evaluations, female participants expected greater improvement in problem areas, whereas male participants anticipated more difficulties during treatment. Female participants expressed greater interest in working with clients, and male participants reported greater comfort in working with clients. Interestingly, the study's findings revealed gender differences in participants' treatment perceptions and expectations for all clients, independent of the client's sexual orientation. First, male participants indicated greater comfort in working with the clients than did female

participants. This result is consistent with existing literature that describes men as evaluating themselves as generally more competent and efficacious than do women (e.g., Gilbert, 1992; Hyde, 1991). Second, the study's results demonstrated that female participants were more focused on relationship issues than were male participants. For instance, female participants reported greater interest in working with clients than did male participants. Additionally, content analyses results suggested that female participants identified relationship issues as the most appealing aspect of the client more frequently than did male participants. This finding is also consistent with existing literature (e.g., Chodorow, 1978; Miller, 1986), which describe women's identity and life experiences within a relational context.

With respect to existing literature on LGB issues, this study's results about the significance of participant gender are quite consistent with findings of other studies about attitudes and treatment practices with LGB individuals. Every study that has investigated counselor gender has found it to be a significant factor in relation to attitudes or treatment practices (Bieschke & Matthews, 1996; Garfinkle & Morin, 1978; Gelso et al., 1995; Liddle, 1996; Mohr & Rochlen, 1999; Thompson & Fishburn, 1977). Further, several of these studies have reported that women exhibit more positive attitudes toward LGB individuals than do men (Garfinkle & Morin, 1978; Mohr & Rochlen, 1999; Thompson & Fishburn, 1977).

A possible explanation for these discrepancies in male and female participants' ratings of clients may involve differences in the socialization of men and women (Pleck, 1981; Westkott, 1986). Specifically, it has been suggested that male counselors are more likely than female counselors to stereotype clients (Scher & Good, 1990; Unger & Crawford, 1992), which may help to account for differences in attitudes and attributions of responsibility between male and female participants that were found in this study. This explanation may also account for findings

of other studies that have indicated that women exhibit more positive attitudes toward LGB individuals than do men (Garfinkle & Morin, 1978; Mohr & Rochlen, 1999; Thompson & Fishburn, 1977). Such an explanation is tentative at best, however, as no empirical studies have investigated possible reasons for differences in male and female counselors' attitudes toward LGB clients.

Another notable outcome of this study is evidence of an interaction effect between participant gender and client sexual orientation. A significant interaction effect for participant gender and client sexual orientation was found for two items on the TPOEQ. Female participants expected greater improvement in depressive symptoms for bisexual clients than for heterosexual clients, and these ratings were significantly higher than male participants' ratings of all clients. Male participants indicated a greater likelihood that LGB clients would threaten to harm someone than for heterosexual clients, and these ratings were significantly higher than female participants' ratings of all clients.

Content analyses findings provided some additional support for an interaction effect between participant gender and client sexual orientation. Results indicated that male participants more frequently identified sexual orientation as the least appealing aspect of the client, and these responses occurred more frequently for bisexual clients than for lesbian and gay clients. Also, heterosexual female participants reported the client's isolation and loneliness as least appealing somewhat more frequently for lesbian and bisexual female clients than did other participants.

Only one other study has examined potential interaction effects between counselor gender and client sexual orientation (Gelso et al., 1995). Results from this study provide mixed support for the findings of Gelso et al. (1995). Although both Gelso et al. (1995) and this study found a significant interaction effect between counselor gender and client sexual orientation, the

specific nature of the interaction effect differed. This study determined that female psychologists evaluated bisexual clients more positively than do male psychologists in comparison to heterosexual clients. Gelso et al. (1995) reported that female counselors evaluated lesbian clients with greater bias (less accuracy in cognitive recall) than did male counselors in comparison to heterosexual female clients. These are the only two studies that have investigated a potential interaction effect between counselor gender and client sexual orientation, and it is unclear how to interpret the findings of these two studies without any other empirical or theoretical literature. It may be that female counselors are more likely to evaluate LGB clients more positively and less accurately than do male counselors and that there is no such difference for heterosexual clients. Another possibility is that female counselors and male counselors differ in their reactions to clients, perhaps with female counselors adopting a more positive attitude in relationships with LGB clients and male counselors being comparatively more problem-focused. Such conclusions are entirely speculative, however, and any interpretation of the results of the two studies together are inconclusive until there is further research on the interaction between counselor gender and client sexual orientation.

For one dependent variable in this study there was a main effect for client gender. Female clients were rated more favorably than were male clients on the dynamism factor of the SD, meaning that participants considered female clients to be stronger, more powerful, and more active than male clients were. This unexpected result is difficult to explain, as there has been no empirical or theoretical literature specifically addressing the influence of client gender per se upon counselors' attitudes and treatment practices with LGB clients.

The main effect for client gender may have resulted from participants' reactions to the vignette. If participants believed that male clients should act in a stereotypically masculine way

(e.g., not crying about problems), they would have been more likely to consider the hypothetical male client as relatively weak (Brannon, 1985; Gilbert, 1992; Scher, Stevens, Good, & Eichenfield, 1987). In contrast, if participants expected female clients to act in a stereotypically feminine manner (e.g., not expressing anger about problems), they would have been more likely to find the hypothetical female client to be relatively strong (Gilbert, 1992).

With the exception of the interaction effects between participant gender and client sexual orientation previously discussed, expected quantitative differences in participants' attitudes and clinical evaluations among client conditions were otherwise unsupported. This lack of significant differences in participants' reported attitudes and clinical evaluations fails to support much of the theoretical and empirical literature on counselor attitudes and treatment practices with LGB clients (e.g., Buhrke, 1989; Casas, Brady, & Ponterotto, 1983; Firestein, 1996; Garnets et al., 1991; McHenry & Johnson, 1993; Mohr & Rochlen, 1999; Phillips & Fischer, 1998; Rudolph, 1990). Several possibilities could explain this finding. It may be that there are truly no differences among licensed psychologists' attitudes and clinical evaluations for lesbian female, gay male, bisexual female, bisexual male, heterosexual female, and heterosexual male clients beyond those that have been discussed above. Given the findings of the study's content analyses and the body of literature on counselor attitudes and treatment practices with LGB individuals, this explanation seems suspect.

In contrast to these findings, content analyses results seem to suggest some differences in participants' responses to open-ended questions depending on client sexual orientation. Namely, a few participants identified issues related to sexual orientation as the least appealing aspect of the client most frequently for bisexual clients. A very small fraction of participants reported having an interest in or appreciation for sexual orientation issues in therapy. For bisexual clients,

a handful of participants described sexual orientation issues in ways that invalidated bisexuality as a legitimate sexual identity (e.g., confusion, impulsivity, longstanding identity problems) – a tentative finding that supports the literature on bisexuality (Coleman, 1998; Eliason, 1997; Firestein, 1996; Fox, 1996; Haeberle, 1998; Mohr & Rochlen, 1999; Ochs, 1996; Rust, 1996; Shuster, 1987; Udis-Kessler, 1996; Weise, 1992). In contrast, some participants' responses depicted lesbian and gay clients' sexual orientation issues as more objectionable than illegitimate (e.g., discomfort with a gay or lesbian identity or lifestyle). Overall, results of content analyses suggested that some participants' attitudes about sexual orientation issues seemed to range from indifferent to fairly negative.

Two influences may help to explain these somewhat discrepant findings between the statistical analyses and content analyses regarding client sexual orientation. One possibility is that the results reflect mixed, divergent attitudes toward LGB individuals – a "checkered pattern" (Rudolph, 1988, p. 167) resulting from conflicting messages from professional affiliations (which are more positive regarding sexual orientation issues) and from society as a whole (which is more negative and unaccepting of sexual orientation issues) (Rudolph, 1988). Research has also suggested that counselors espouse more affirming beliefs toward LGB clients in abstract situations (i.e., in response to a clinical vignette) than in experiences that are more real and personal (Rudolph, 1990).

A second possibility is that methodological limitations of the study may have confounded the results. It is possible that participants could have guessed that client sexual orientation was being manipulated in this study, potentially threatening the accuracy of responses or contributing to social desirability bias. Alternately, some participants may not have attended to the client's sexual orientation. In an attempt to disguise the nature of the study, the client's sexual

orientation was not presented as a salient concern, nor were participants directly asked about their reactions regarding the client's sexual orientation. There were also weaknesses in the dependent measures that may have threatened the accuracy of the study's results. The SAS demonstrated poor internal reliability for the attribution of problem solution factor (coefficient alpha = .50), and the TPOEQ – an experimental measure developed specifically for this study – lacked established psychometric data. Another difficulty is that this study does not provide much-needed empirical knowledge about attitudes and treatment issues for LGB clients among ethnic- and racial-minority licensed psychologists. Unfortunately, with few exceptions (e.g., Gelso et al., 1995) the majority of existing empirical studies in this literature domain are based on sample populations that are not highly representative of diverse racial and ethnic groups.

In light of these limitations, though, this study provides several important contributions to the existing literature on counselor attitudes and treatment practices with LGB clients. Most significantly, this study has extended the literature by incorporating several key variables within its scope. First, this study specifically examined bisexuality, which has been addressed in only two other empirical studies (Bieschke & Matthews, 1996; Phillips & Fischer, 1998). Because the bisexuality literature is almost completely theoretical, this study provides an empirical contribution to our knowledge about licensed psychologists' attitudes and treatment considerations with bisexual clients. Second, this study documented the attitudes and clinical evaluations of licensed practicing psychologists. Because most studies in this area have been conducted on counselors or trainees, this study added to existing empirical research by focusing specifically on licensed psychologists who not only work with clients but who are also capable of providing training for other mental health practitioners. This study offers an important empirical contribution by focusing on a population that is capable of providing both clinical and

training experiences. Indeed, the majority of respondents (72.9%) reported that they were involved in some aspect of training within the past year that the study was conducted. Third, this study examined therapist gender as well as potential interaction effects between therapist gender, client gender, and client sexual orientation. As such, this study contributes to a growing body of literature that has found therapist gender to be an influential factor on attitudes and treatment practices with LGB clients (e.g., Bieschke & Matthews, 1996; Garfinkle & Morin, 1978; Gelso et al., 1995; Liddle, 1996).

Several areas for future research are recommended in light of this study's findings. First, subsequent studies should examine counselor gender and interaction effects between counselor gender and client sexual orientation. Every study that has investigated these variables has found them to be important factors influencing counselor attitudes and treatment practices with LGB clients (Bieschke & Matthews, 1996; Garfinkle & Morin, 1978; Gelso et al., 1995; Liddle, 1996; Mohr & Rochlen, 1999; Thompson & Fishburn, 1977). Second, given the nascent state of the bisexuality literature, it would be especially useful for future studies to utilize qualitative methodologies in order to inform both theory and subsequent empirical research. It would also be informative to replicate previous studies in the aim of incorporating or focusing exclusively on bisexuality. Finally, findings of this study also raise important questions about training – an area that was beyond the scope of this project.

The results of this study also present important considerations for practice. The study's overall findings suggest that at least some licensed psychologists may hold mixed and inconsistent attitudes toward LGB clients. Yet this highly optimistic explanation contradicts evidence from the literature on counselor attitudes and treatment practices with LGB clients (Bieschke & Matthews, 1996; Buhrke, 1989; Casas et al., 1983; Davison & Wilson, 1973;

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Garfinkle & Morin, 1978; Garnets et al., 1991; Gelso et al., 1995; Glenn & Russell, 1986; Liddle, 1996, in press; Phillips & Fischer, 1998; Thompson & Fishburn, 1977). An alternative interpretation is that these findings actually may be reflective of licensed psychologists' mixed and "checkered" (Rudolph, 1988, p. 167) attitudes toward LGB clients. Given the limited state of intentional training and supervision experiences that promote personal awareness and knowledge about LGB individuals, issues, and culture (Buhrke, 1989; Phillips & Fischer, 1998), it is likely that at least some licensed psychologists would hold inconsistent attitudes (Rudolph, 1990).

Finally, it is important to distinguish between biased and affirmative therapeutic practice. Some licensed psychologists may engage in therapeutic relationships with LGB clients that are unbiased but may not necessarily be affirmative. Overall, the challenge for licensed psychologists (and indeed for all mental health practitioners) is to develop an attitude and a therapeutic relationship with LGB clients that is more than neutral. Rather, affirmative therapy with LGB clients requires counselors to balance objective and proactive roles in the aim of helping these individuals to develop healthy ways of advocating for themselves.

Figure 1
Follow-Up Univariate Analysis of Covariance for the Interaction Effect for Participant Gender and Client Sexual Orientation on TPOEQ Item #2 (How likely is it that Chris' depressive symptoms will improve with individual therapy?)

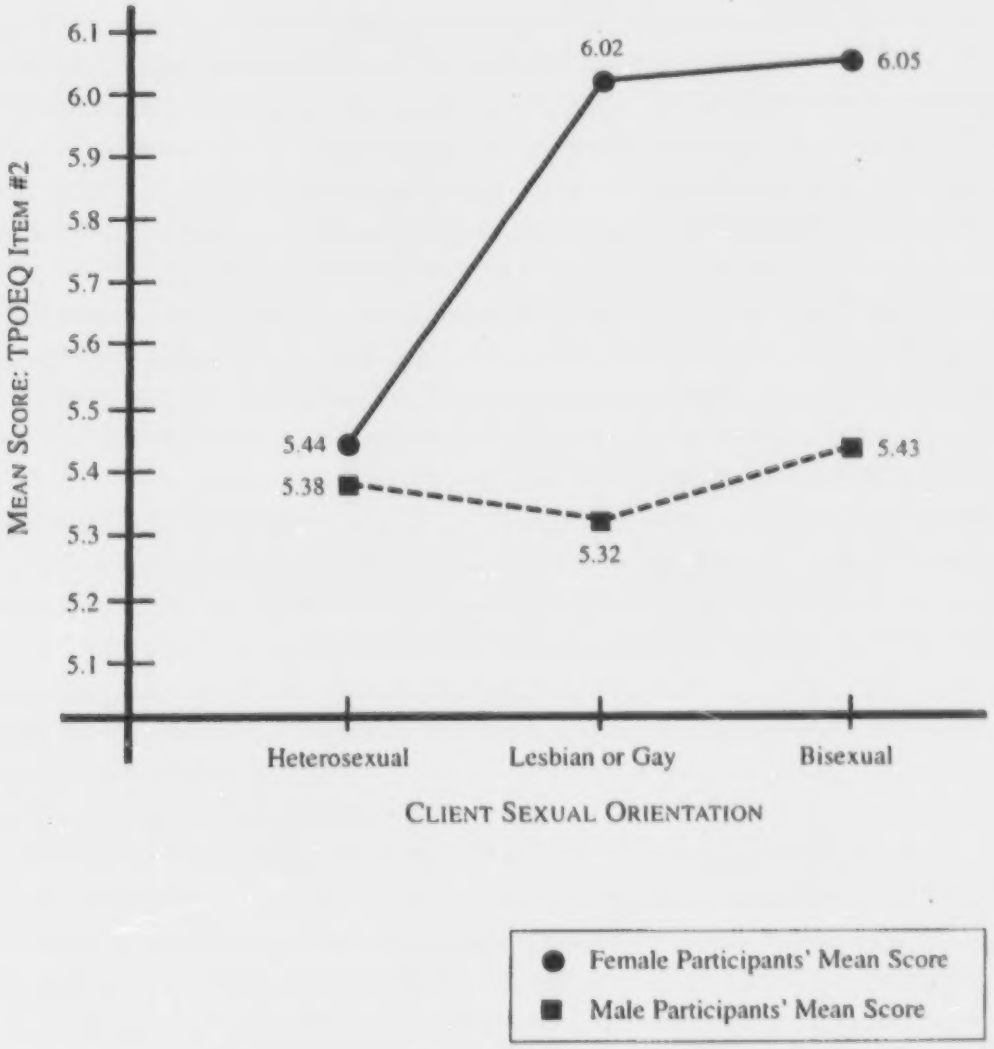

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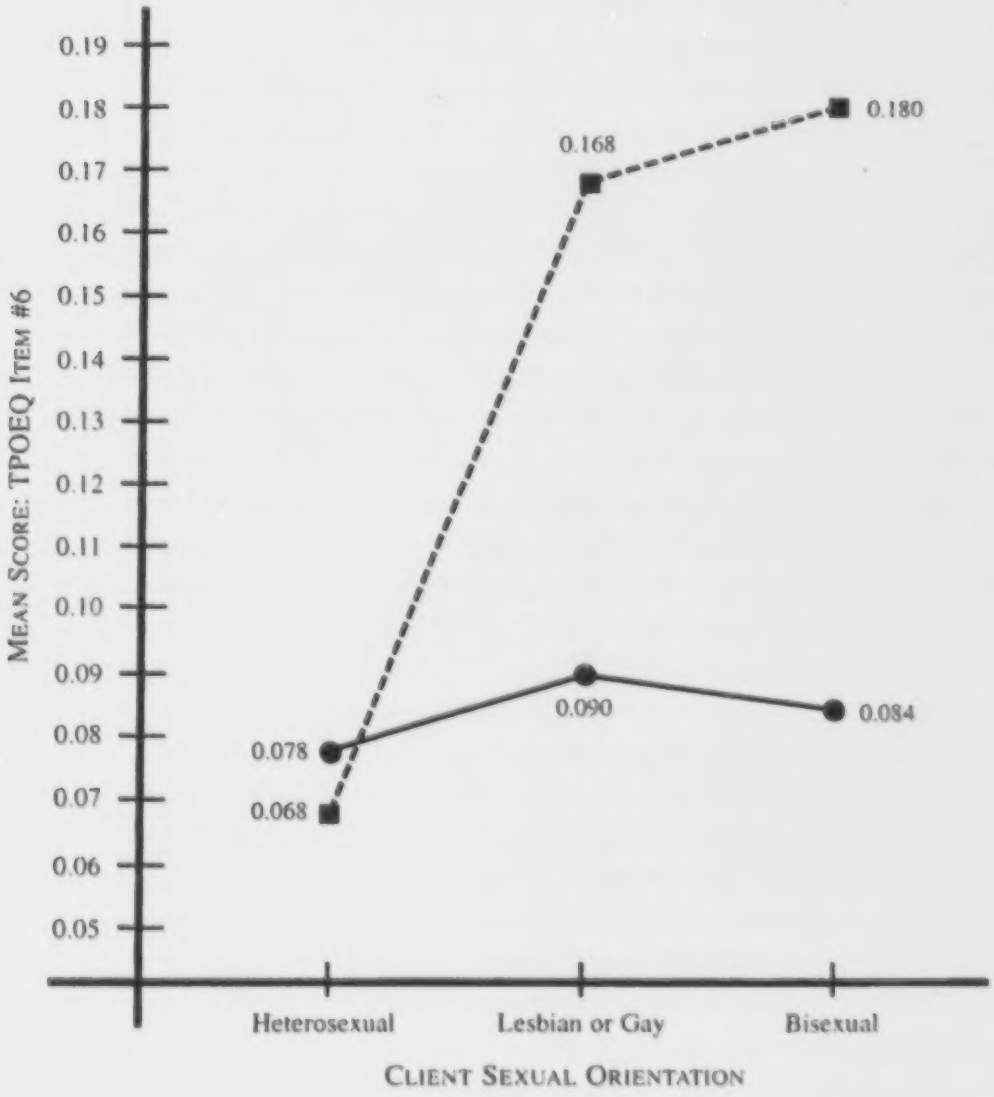
Figure 2 :
Follow-Up Univariate Analysis of Covariance for the Interaction Effect for Participant Gender and Client Sexual Orientation on TPOEQ Item #6 (How likely is it that Chris will threaten to physically harm another person during the course of individual therapy?)



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References

American Psychiatric Association (1994). Diagnostic and statistical manual of mental disorders (4th ed.). Washington, DC: Author.

Bieschke, K. J, & Matthews, C. (1996). Career counselor attitudes and behaviors toward gay, lesbian, and bisexual clients. Journal of Vocational Behavior, 48, 243-255.

Bieschke, K. J., McClanahan, M., Tozer, E., Grzegorek, J. L., & Park, J. (2000). Programmatic research on the treatment of lesbian, gay, and bisexual clients: The past, the present, and the course for the future. In R. M. Perez, K. A. DeBord, & K. J. Bieschke (Eds.), Handbook of counseling and therapy with lesbian, gay, and bisexual clients (pp. 309-336). Washington, DC: American Psychological Association.

Biro, V. (1995). Outline of the concept of alcohol neuropsychological structure. Studia Psychologica, 37, 241-249.

Brannon, R. (1985). A scale for measuring attitudes about masculinity. In A. Sargent (Ed.), Beyond sex roles (pp. 110-116). St. Paul, MN: West Publishing.

Buhrke, R. A. (1989). Female student perspectives on training in lesbian and gay issues. The Counseling Psychologist, 17, 629-636.

Casas, J. M., Brady, S., & Ponterotto, J. G. (1983). Sexual preference biases in counseling: An information processing approach. Journal of Counseling Psychology, 30, 139-145.

Chodorow, N. (1978). The reproduction of mothering. Berkeley, CA: University of California Press.

Coleman, E. (1998). Paradigmatic changes in the understanding of bisexuality. In E. J. Haeberle & R. Gindorf (Eds.), Bisexualities: The ideology and practice of sexual contact with both men and women (pp. 107-112). New York: Continuum.

Davison, G. C., & Wilson, G. T. (1973). Attitudes of behavior therapists toward homosexuality. Behavior Therapy, 4, 686-696.

Eliason, M. J. (1997). The prevalence and nature of biphobia in heterosexual undergraduate students. Archives of Sexual Behavior, 26, 317-326.

Fassinger, R. E. (1991). The hidden minority: Issues and challenges in working with lesbian women and gay men. The Counseling Psychologist, 2, 157-176.

Firestein, B. A. (1996). Bisexuality as paradigm shift: Transforming our disciplines. In B. A. Firestein (Ed.), Bisexuality: The psychology and politics of an invisible minority (pp. 263-291). Thousand Oaks, CA: Sage.

Fox, R. C. (1996). Bisexuality in perspective: A review of theory and research. In B. A. Firestein (Ed.), Bisexuality: The psychology and politics of an invisible minority (pp. 3-52). Thousand Oaks, CA: Sage.

Garfinkle, E. M., & Morin, S. F. (1978). Psychologists' attitudes toward homosexual psychotherapy clients. Journal of Social Issues, 34, 101-112.

Garnets, L., Hancock, K. A., Cochran, S. D., Goodchilds, J., & Peplau, L. A. (1991). Issues in psychotherapy with lesbians and gay men: A survey of psychologists. American Psychologist, 46, 964-972.

Gelso, C. J., Fassinger, R. E., Gomez, M. J., & Latts, M. G. (1995). Countertransference reactions to lesbian clients: The role of homophobia, counselor gender, and countertransference management. Journal of Counseling Psychology, 42, 356-364.

George, D., & Mallery, P. (2000). SPSS for Windows step by step: A simple guide and reference, 9.0 update (2nd Ed.). Boston: Allyn and Bacon.

Gilbert, L. A. (1992). Gender and counseling psychology: Current knowledge and directions for research and social action. In S. D. Brown & R. W. Lent (Eds.), Handbook of counseling psychology (2nd ed., pp. 383-416). New York: John Wiley & Sons.

Glenn, A. A., & Russell, R. K. (1986). Heterosexual bias among counselor trainees. Counselor Education and Supervision, 26, 222-229.

Haeberle, E. J. (1998). Bisexuality: History and dimensions of a modern scientific problem. In E. J. Haeberle & R. Gindorf (Eds.), Bisexualities: The ideology and practice of sexual contact with both men and women (pp. 13-51). New York: Continuum.

Hall, R. C. W. (1995). Global Assessment of Functioning: A modified scale. Psychosomatics, 36, 267-275.

Hayes, J. A., & Wall, T. N. (1998). What influences clinicians' responsibility attributions? The role of problem type, theoretical orientation, and client attribution. Journal of Social and Clinical Psychology, 17, 69-74.

Jones, S. H., Thornicroft, G., Coffey, M., & Dunn, G. (1995). A brief mental health outcome scale: Reliability and validity of the Global Assessment of Functioning (GAF). British Journal of Psychiatry, 166, 654-659.

Karuza, J., Zevon, M. A., Gleason, T. A., Karuza, C. M., & Nash, L. (1990). Models of helping and coping, responsibility attributions, and well-being in community elderly and their helpers. Psychology and Aging, 5, 194-208.

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Kennedy, C. C., Madra, P., & Reddon, J. R. (1999). Assessing treatment outcomes in psychogeriatric patients: The utility of the Global Assessment of Functioning. Clinical Gerontologist, 20, 3-11.

Liddle, B. J. (1996). Therapist sexual orientation, gender, and counseling practices as they relate to ratings of helpfulness by gay and lesbian clients. Journal of Counseling Psychology, 43, 394-401.

Liddle, B. J. (1997). Gay and lesbian clients' selection of therapists and utilization of therapy. Psychotherapy, 34, 11-18.

Liddle, B. J. (in press). Gay and lesbian clients' ratings of psychiatrists, psychologists, social workers, and counselors. Journal of Gay and Lesbian Psychotherapy.

Manassis, K., & Hood, J. (1998). Individual and familial predictors of impairment in childhood anxiety disorders. Journal of the American Academy of Child and Adolescent Psychiatry, 37, 428-434.

McCracken, J. E., Hayes, J. A., & Dell, D. (1997). Attributions of responsibility for memory problems in older and younger adults. Journal of Counseling and Development, 75, 385-391.

McHenry, S. S., & Johnson, J. W. (1993). Homophobia in the therapist and gay or lesbian client: Conscious and unconscious collusions in self-hate. Psychotherapy, 30, 141-151.

Miller, J. B. (1986). Toward a new psychology of women (2nd ed.). Boston: Beacon Press.

Mohr, J. J., & Rochlen, A. B. (1999). Measuring attitudes regarding bisexuality in lesbian, gay male, and heterosexual populations. Journal of Counseling Psychology, 46, 353-369.

Ochs, R. (1996). Biphobia: It goes more than two ways. In B. A. Firestein (Ed.), Bisexuality: The psychology and politics of an invisible minority (pp. 217-239). Thousand Oaks, CA: Sage.

Osgood, C. E., Suci, G. J., & Tannenbaum, P. H. (1957). The measurement of meaning. Urbana, IL: University of Illinois Press.

Oyama, T., Yamada, H., & Iwasawa, H. (1998). Synesthetic tendencies as the basis of sensory symbolism: A review of a series of experiments by means of a semantic differential. Psychologia: An International Journal of Psychology in the Orient, 41, 203-215.

Patterson, D. A., & Lee, M. S. (1995). Field trial of the Global Assessment of Functioning Scale - Modified. American Journal of Psychiatry, 152, 1386-1388.

Pedhazur, E. J., & Schmelkin, L. P. (1991). Measurement design and analysis: An integrated approach. Hillsdale, NJ: Laurence-Erlbaum.

Phillips, J. C., & Fischer, A. R. (1998). Graduate students' training experiences with lesbian, gay, and bisexual issues. The Counseling Psychologist, 26, 712-734.

Piersma, H. L., & Boes, J. L. (1997). The GAF and psychiatric outcome: A descriptive report. Community Mental Health Journal, 33, 35-41.

Pleck, J. H. (1981). Men's power with women, other men, and society: A men's movement analysis. In R. A. Lewis (Ed.), Men in difficult times: Masculinity today and tomorrow (pp. 251-333). Greenwich, CT: JAI Press.

Rey, J. M., Starling, J., Wever, C., Dossetor, D. R., & Plapp, J. M. (1995). Inter-rater reliability of Global Assessment of Functioning in a clinical setting. Journal of Child Psychology and Psychiatry, 36, 787-792.

Robert, P., Aubin, V., Dumarcet, M., Braccini, T., & Souetre Darcourt, G. (1991). Effect of symptoms on the assessment of social functioning: Comparison between Axis V of DSM-III-R and the Psychosocial Aptitude Rating Scale. European Journal of Psychiatry, 6, 67-71.

Rudolph, J. (1988). Counselors' attitudes toward homosexuality: A selective review of the literature. Journal of Counseling and Development, 67, 165-168.

Rudolph, J. (1990). Counselors' attitudes toward homosexuality: Some tentative findings. Psychological Reports, 66, 1352-1354.

Rust, P. C. (1996). Monogamy and polyamory: Relationship issues for bisexuals. In B. A. Firestein (Ed.), Bisexuality: The psychology and politics of an invisible minority (pp. 127-148). Thousand Oaks, CA: Sage.

Scher, M., & Good, G. E. (1990). Gender and counseling in the twenty-first century: What does the future hold? Journal of Counseling and Development, 68, 388-391.

Scher, M., Stevens, M., Good, G. E., & Eichenfield, G. (1987). The handbook of counseling and psychotherapy with men. Newbury Park, CA: Sage.

Shuster, R. (1987). Sexuality as a continuum: The bisexual identity. In Boston Lesbian Psychologies Collective (Ed.), Lesbian psychologies (pp. 56-71). Urbana, IL: University of Illinois Press.

Skrandies, W. (1998). Evoked potential correlates of semantic meaning – A brain mapping study. Cognitive Brain Research, 6, 173-183.

Svanborg, P., Gustavsson, J. P., & Weinryb, R. M. (1999). What patient characteristics make therapists recommend psychodynamic psychotherapy or other treatment forms? Acta Psychiatrica Scandinavica, 99, 87-94.

Tabachnick, B. G., & Fidell, L. S. (1996). Using multivariate statistics (3rd ed.). New York: Harper Collins College Publishers.

Thompson, G. H., & Fishburn, W. R. (1977). Attitudes toward homosexuality among graduate counseling students. Counselor Education and Supervision, 17, 121-130.

Udis-Kessler, A. (1996). Challenging the stereotypes. In Off Pink Collective (Ed.), Bisexual horizons: Politics, histories, lives (pp. 45-57). London: Lawrence & Wishart.

Unger, R., & Crawford, M. (1992). Women and gender: A feminist psychology. New York: McGraw-Hill.

Weise, E. R. (1992). Introduction. In E. R. Weise (Ed.), Closer to home: Bisexuality and feminism (pp. 281-310). Seattle, WA: Seal Press.

Westkott, M. (1986). The feminist legacy of Karen Horney. New Haven, CT: Yale University Press.

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